TASK FORCE ON HEALTH SERVICES FOR THE ELDERLY

INTERIM REPORT C

OPTIONS FOR LIVING: HOUSING AND HOME CARE (WITH SELECTED ASPECTS OF LONG-TERM INSTITUTIONAL CARE AND ACUTE CARE SERVICES)

October, 1990

Manitoba Health

92-03793/

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November 13, 199

Dear Colleague:

The Task Force on Health Services for the Elderly has completed an Interim Report entitled "Options for Living: Housing and Home Care" (With Selected Aspects of Long-Term Institutional Care and Acute Care Services). This Interim Report was formally received by the Health Advisory Network Steering Committee.

Consistent with the Minister of Health's desire to ensure adequate consultation, the Steering Committee invites input from those affected by the recommendations of the Task Force before it formalizes its own recommendations. A copy of the Interim Report of the Task Force is enclosed for your review and response. Copies have been distributed to more than twenty organizations and groups for comment. Other interested individuals may request a copy of the Interim Report from this office.

The sequence of the consultation process is outlined below:

1) The Interim Report of the Task Force was received by the Steering Committee.

2) The Steering Committee distributes the Interim Report to interested parties in the community for comment.

3) The community responses are to be forwarded to the Task Force for review in January, 1991.

4) The Task Force will submit its final Report to the Steering Committee, taking into account the reactions to the Interim Report.

5) The Steering Committee will review the final report of the Task Force to formulate options and recommendations for consideration by the Minister of Health.

Your written response to the Interim Report of the Task Force should be received on or before January 11, 1991.

Please send **TWENTY** (20) copies of your comments to:

Health Advisory Network
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Yours truly,

Brian Edmundson for

Arnold Naimark, M.D.
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Enc.

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RECOMMENDATIONS

Recommendation #1: The Department of Health continue to recognize the role of supportive housing in maintaining the health of elders and allowing aging in place, and the Department promote and develop sound initiatives in supportive housing together with the Department of Housing and other agencies.

Recommendation #2: Representatives from the Housing and Health Departments discuss together how consumers can be made aware of supportive housing and modification options and how they may be assisted in instances where these options can help maintain them in their own homes.

Recommendation #3: The Departments of Health and Housing incorporate an appreciation of cultural, health, caregiving, and other needs in establishing housing policy options for elders.

Recommendation #4: The Departments of Health and Housing change the 1-bedroom rule as a requirement for eligibility for funding.

Recommendation #5: Individuals from the Housing Department of the Manitoba Government, Manitoba Association of Social Housing Managers, and Manitoba Health together decide upon a variety of options for the vacant bachelor suites and ensure implementation as soon as possible.

Recommendation #6: The Office of Continuing Care assessment form be used for residents of homes approved by the Office of Residential Care, and staff be appropriately trained in the use of these forms.

Recommendation #7: Programming be reinstated in the Office of Residential Care and be linked to quality of life of the residents.

Recommendation #8: Representatives from the Office of Continuing Care, the operators of guest homes, and where possible residents of guest homes, be informed of the policy of the Office of Continuing Care regarding the eligibility of guest home residents to receive their services.

Recommendation #9: The Office of Residential Care examine their policy of approving guest homes with more than five residents. (This may necessitate a grandfather clause for existing homes which are larger.)

Recommendation #10: The Departments of Housing and Health examine the possibility of establishing residential units similar to Abbyfield houses and involve private and non-profit organizations in these discussions.

Recommendation #11: The Minister of Health receive advice on and then implement a structure which will ensure explicit accountability for the Home Care program.

Recommendation #12: That OCC control the dollars for which it sets standards and is accountable. The option of having line authority to OCC rather than to the region should be examined within this process.

Recommendation #13: Once a proper information system is in place, budget targets remain flexible in order to meet needs but units must be accountable for budget expenditures. Work unit measurement be introduced for those units arguing the need for more dollars.

Recommendation #14: The case coordinator/resource coordinator staff complement for the Home Care program be increased according to established case load ratios and work load indices and that these ratios be targeted for each region according to age/sex population adjustments and according to regional diversities in the region.

Recommendation #15: The OCC develop explicit implementation criteria for deciding eligibility of short-term care.

Recommendation #16: Information pamphlets on the Home Care program be widely distributed and be available in languages in addition to English.

Recommendation #17: The Department of Health pursue the option of contracting out, at least on a pilot basis, the provision of services to facilities and other interested agencies.

Recommendation #18: The Office of Continuing Care seriously examine the provision of adequate training for one person to conduct multidisciplinary assessments as a cost effective replacement of the current dual assessment system. This option could include a broader scope of practitioners to conduct assessments than are currently hired and Home Care could ensure that necessary expertise would be available for further consult where necessary.

Recommendation #19: The Minister of Health take action immediately to remove the inherent conflict of interest in the short-term assessments currently being performed by the V.O.N.

Recommendation #20: OCC examine the feasibility of having the long-term care sector represented on the panel for placement, ensuring that no individual who may be in conflict of interest would sit on any particular panel.

Recommendation #21: The Minister of Health authorize and Treasury Board fund immediately a proper comprehensive information system that will record client service, management, and financial data for the Office of Continuing Care.

Recommendation #22: The Department of Health of the Manitoba government continue to endorse community long-term care for meeting the needs of elders as equally important to long-term institutional care.

Recommendation #23: Given Canada's and Manitoba's relatively high rate of institutionalization and given the current inadequate staffing of the Home Care program, it is recommended that the ratio of long-term institutional beds to population be determined for Manitoba elders after Home Care has adequate management and case and resource coordinators and other problems are corrected, and PCHs are also adequately staffed and sufficient time has been allowed to assess where the pressure points are.

Recommendation #24: After the completion of the 230 new PCH beds at Municipal Hospital and the 230 new beds in the Northeast quadrant that no additional PCH beds be built until Home Care has been adequately staffed and an appropriate rate of institutionalization for Manitoba's elders is determined.

Recommendation #25: The MHSC appropriately fund and adequately staff PCHs for the heavy care being provided.

Recommendatior #26: The development of a reliable, accurate and responsible patient information system for long-term care facilities be linked with a similar data system for acute care hospitals.

Recommendation #27: The feasibility of contracting with the hospitals for the discharge planning process be examined in detail.

Recommendation #28: The Task Force on Alternative Health Care Strategies examine ways to monitor medical intervention, to increase consumer participation, and to increase all participants' awareness of both the costs and medical outcomes of interventions.

Recommendation #29: The Task Force on Alternative Health Care Strategies examine means to ensure that when new interventions or procedures for new interventions are introduced into the health care system, that as a matter of policy, existing aspects of the system will be examined to see where decreases can occur.

Recommendation #30: The Minister of Health establish a working group to explore ways to ensure elders can access different types of care without necessarily going through a physician.

Recommendation #31: The Task Force on Alternative Health Care Strategies examine ways to educate the public on individual responsibiiity for health and the allocation of health care dollars.

TASK FORCE ON HEALTH SERVICES FOR THE ELDERLY
INTERIM REPORT C
OPTIONS FOR LIVING: HOUSING AND HOME CARE (WITH SELECTED ASPECTS OF LONG-TERM INSTITUTIONAL CARE AND ACUTE CARE SERVICES)

Introduction

This is the third in a series of reports submitted by the Task Force on Health Services for the Elderly. This report deals with housing and home care, both services provided within the community. It deals with selected aspects of long-term institutional care and some matters related to acute care but other issues in both these areas are dealt with in a later report. The issues discussed here were determined largely because the report of the Task Force on Extended Treatment Beds was submitted and we were asked to comment on the need for long-term institutional beds. Because the issue of long-term institutional care is tied to the availability of home care services, the two are dealt with together. Housing is included because it is a community service which is frequently related to the receipt of home care. Acute care enters as the most costly sector within the system.

Housing

Marguerite Chown (Past-President of the Manitoba Society of Seniors) has noted that three major concerns consistently arise as important contributors to a problem-free and satisfying environment. One of these three is adequate housing (the other two being appropriate health services and adequate income). It is our belief that housing is more than mere shelter. It is an essential component for maintaining and enhancing the quality of life and health of Manitoba's elders.

In their Task Force report, the Metropolitan Toronto District Health Council (Schwenger, 1988) argues that housing, and specifically sheltered housing, represents one of:

> The most promising long-term housing options for assisting the well but functionally impaired and/or socially deprived and isolated elderly, in retaining their independence, privacy, and dignity.

This report categorizes the range of housing alternatives available to older Canadians into three categories: independent living, supported independent living, and dependent living. It is the middle category of supported independent living where major housing innovations for Canadian elders are taking place at the current time (Chappell, 1990). Also known as sheltered housing, it is perhaps best known in the United Kingdom, where it strives to achieve a balance between care and independent activities within a continuum of increasingly protected sheltered options. In the U.K. sheltered housing consists basically of grouped dwellings, sharing certain facilities such as dining and recreation, the 24-hour presence of a "warden" or housekeeper, and an inter-communication system. The housekeeper is available mainly for emergency calls and serves as the residents' counsellor and advocate. He or she acts as liaison to the broader community.

Various levels of sheltered housing are offered in the U.K. through to a very sheltered or extra care category for the more dependent elderly which includes greater care elements such as additional wardens, provision of meals, care assistance, and extra communal facilities. In the U.K. sheltered housing does not include any health professionals on staff. They are used when necessary from the regular ranks of the national health service. Tinker (1984) estimates that around 5% of elders in the U.K. live in sheltered housing, with another 5% living in dwellings especially designed or adapted for elders. It

is not unusual for individuals to die in sheltered housing (indeed the majority do) rather than be moved to hospital or institutional care. Schwenger (1988) argues that the availability of sheltered housing is in large part responsible for their low rate of institutionalization.

It is noteworthy that supportive housing is an option which Canadian elders themselves prefer. Baker (1987) conducted a survey of community living elders in Victoria, B.C., asking them about their preference for alternative housing should their health fail. Most seniors were interested in either staying at home with help from community services or moving into a seniors housing project where services were available. Fully three-quarters say they would want to move into a seniors project where services are available when age related disabilities strike. When asked about their interest in several components of sheltered housing, half of those age 75 and over expressed a wish for an alarm system or person in the building they could call on in an emergency. One-third were interested in an optional meal service and one-quarter in having a person call on them every day. It is also to be noted that the two items of highest need were not part of the sheltered housing concept. Both doing housework and shopping emerged as significant problems, particularly for those age 75 and over.

Furthermore, seniors themselves have told us they want to stay in their own homes (in the U.S. see Pynoos, 1989 and Rabushka and Jacobs, 1980; in Australia see Kendig, 1981; in Europe see Tinker, 1987; in Canada see Habitat, 1989). They also want their houses to be adaptable to fit changing needs and they want housing and services as an integrated package which requires holistic coordinated planning. These options chosen by elders themselves permit Aging in Place.

Manitoba, like other provinces, has a mix of housing and service types. The adage a range of options has been accepted when it comes to housing services. However, the range of supportive housing options available is still relatively restricted. It is recommended that:

Recommendation #1: The Department of Health continue to recognize the role of supportive housing in maintaining the health of elders and allowing aging in place, and the Department promote and develop sound initiatives in supportive housing together with the Department of Housing and other agencies.

Two-thirds of older Canadians own their own home; 86% of them are mortgage free (Blackie, 1986; Seniors Info, 1990). Among people 80 and over, over half (56%) own their own home. Furthermore, 80% of the present housing stock will continue to function in the year 2001. The conclusion is obvious. More innovative approaches must be developed to use existing housing. This includes both bringing appropriate supportive services into existing housing and also modifying existing housing for appropriate use by seniors. Modification can be extensive or not so extensive. It can include: wheelchair accessibility; windows which are easy to open and close; light switches which are at eye or shoulder sitting height; grab rails; heat controls, hydro, gas and water meters which are accessible to the elderly readers; counters and sinks which are at a height so elders can sit when using them; stove controls at the front or side to prevent accidents with sleeves or boiling pots; to name only a few. It is recommended that:

Recommendation #2: Representatives from the Housing and Health Departments discuss together how consumers can be made aware of supportive housing and modification options and how they may be assisted in instances where these options can help maintain them in their own homes.

One of the problems encountered in providing supportive housing options in Manitoba, as elsewhere in Canada, is the fact that until very recently housing was built to provide basic shelter only, so the physical building does not always accommodate the delivery of services (such as congregate meals). In addition, housing is a separate administrative jurisdiction which means that continuity of care and coordination of services between health, social services, and housing departments of government are sometimes difficult to implement.

Size of the dwelling is another concern. Policy makers frequently believe (Kendig, 1990) that elders living in space with extra rooms under-utilize their space which leads to a charge that elders are over-housed. Yet the vast majority of home owners do not believe their homes are too large. Indeed, in Manitoba at this time there are hundreds of small bachelor suites which elders refuse to rent. They will pay more even out of scant incomes (of no more than the OAS and GIS) in order to secure a one-bedroom apartment.

There are at the present time several alternatives being considered for these bachelor suites, including: beautifying the suites and including curtains as barriers between the sleeping area and other areas of the room; where the physical structure allows, combining them into 2-bedroom suites; where some are clustered together, using them for more frail elders and providing a greater level of care; converting some into units for relatives to rent who come to visit seniors in the building; conversion into recreational lounges; or renting them to younger tenants such as students. These empty suites have a lesson -

when new buildings are constructed, they should be built with greater flexibility to allow Aging in Place.

In the meantime, if the presenters who appeared before the Task Force are correct, anything beyond a 3% vacancy rate means the operation is running at a loss, a solution to these empty bachelor suites must be found immediately. In addition, it is our understanding that the Manitoba Housing and Renewal Corporation still insists only bachelors or 1-bedroom suites are to be built if MHRC contributes to the funding. This does not take elders' wishes into account, nor alternative living arrangements (such as two sisters who wish separate bedrooms, a spouse or other caregiver who requires a separate bedroom to ensure a night's sleep, or cultural preferences such as natives who wish to have multigenerational living arrangements). In other words, existing policy has created problems (such as an excess of empty bachelor suites) which are also costly (housing units frequently run at a loss). It is recommended that:

Recommendation #3: The Departments of Health and Housing incorporate an appreciation of cultural, health, caregiving, and other needs in establishing housing policy options for elders.

Recommendation #4: The Departments of Health and Housing change the 1-bedroom rule as a requirement for eligibility for funding.

Recommendation #5: Individuals from the Housing Department of the Manitoba Government, Manitoba Association of Social Housing Managers, and Manitoba Health together decide upon a variety of options for the vacant bachelor suites and ensure implementation as soon as possible.

For example, one option arises from a growing concern that sufficient care options are not currently available in the community. The Task Force heard requests for foster homes for frail elders, for suites in elderly person's housing (EPHs) for some to leave personal care homes (PCHs) but with guarantees of a bed if the need arises, and for clustered suites with appropriate workers for the slightly cognitively impaired or physically frail. One could establish an area where bachelor suites are clustered together for use for heavier care with appropriate staff. This option, however, should be followed closely and compared with other individuals with similar problems to see if this option decreases hospital utilization among such a group of residents.

One of the housing options available in Manitoba refers to residential care (ORC) or guest homes. Manitoba was the first province in the country to require these homes be licensed. However, they have no programming attached to them, rather they are viewed purely as housing alternatives. ORC regulates physical structure only. They are designed for residents who require 24-hour supervision (meaning the presence of an individual in the home). Guest home operators hire staff who can provide that supervision. This frequently includes feeding individuals, bathing them, etc. No professional staff are hired. Task Force members noted that these operators are providing a service not available elsewhere in the system and that a proportion of these residents would otherwise be in hospitals or personal care homes.

Furthermore, there is a clear lack of communication in regards to the availability of home care services for these individuals. The Task Force heard from the Office of Residential Care, an operator of a larger guest home, and the operator of a smaller guest home that guest home residents were ineligible for any home care services. The Office of Continuing Care, however, informs the

Task Force that residents are eligible s would any other individual residing in their own homes. The residents, however, are not eligible for those services they are paying the operator to provide, such as meal preparation. They are eligible for other services such as home nursing care. There is also the issue of the clientele served by this housing alternative. Many of the residents of guest homes could be considered socially marginal individuals. Some of these individuals used to reside in mental institutions. The extent to which they are aware that they are eligible for home care services is in question. In other words, there is reason to believe neither the guest home operators nor the residents know they are eligible for some home owner services.

There is another issue which refers to the eligibility of guest home residents for all home care services, as they remain in these homes over the years and their health deteriorates beyond the level when they initially entered and for some to the point where they are waiting placement for PCH. Most of these people have no place to go until they are transferred to a PCH. In these instances they should be eligible for all home care services as would any individual living in their own home. Such an option permits aging in place for residents whose needs have exceeded the care the home operators are expected to provide.

Finally, these guest homes seem to suffer from an "image problem". Workers in other parts of the system may not be eager to refer these clients for home care, or indeed to refer clients to these homes to live. Yet the owners of these guest homes are providing a service which some individuals find necessary.

One of the features of guest homes is the home like atmosphere. However, in the opinion of Task Force members, it is difficult to maintain this advantage when the number of residents is large (exceeds 5). It is recommended that:

Recommendation #6: The Office of Continuing Care assessment form be used for residents of homes approved by the Office of Residential Care and staff be appropriately trained in the use of these forms.

Recommendation #7: Programming be reinstated in the Office of Residential Care and be linked to quality of life of the residents.

Recommendation #8: Representatives from the Office of Continuing Care, the operators of guest homes, and where possible residents of guest homes, be informed of the policy of the Office of Continuing Care regarding the eligibility of guest home residents to receive their services.

Recommendation #9: The Office of Residential Care examine their policy of approving guest homes with more than five residents. (This may necessitate a grandfather clause for existing homes which are larger.)

This brings to mind the Abbyfield type concept of sheltered housing for seniors which is not currently available in Manitoba. Abbyfield houses are intended to look and function like regular houses in residential areas. They were founded and are perhaps best known in England, then spread to Australia and Ireland. Abbyfield houses now operate in other parts of Canada. The intent is to provide the kinds of houses that remind elderly people of home and not an institution, that provide security and companionship. Each person has a bed sitting room large enough for basic furnishings and closet requirements plus an

ensuite toilet and wash basin. Other areas, such as the lounge, dining room, kitchen, utility room, and bath areas are all common. In the original concept, individuals must be mentally alert, healthy, and mobile in order to live in these homes, although there is no reason why it cannot be adapted for aging in place. The home provides a resident housekeeper, sharing of communal facilities, and an alarm system linking the tenants to the housekeeper. This is a non-profit option which the Government of Manitoba may wish to consider. It is recommended that:

Recommendation #10: The Departments of Housing and Health examine the possibility of establishing residential units similar to Abbyfield houses and involve private and non-profit organizations in these discussions.

As part of this exercise, the desirability of having some of the guest homes converted into such houses should be examined.

More will be said about providing homes in the community in a later report when discussing the mentally retarded and the post mentally ill who have become elderly.

In sum, Manitoba currently has a mix of housing. It is important to emphasize that not all individuals want services within their home or building. Others need and desire many services. It is through extending the range of housing options that Manitoba seniors will have appropriate choices in which to live. Home care is fundamental to the provision of many supportive housing options. Home care is the topic of the next section.

Home Care

Any discussion of Manitoba's home care program must recognize that it is widely acclaimed as offering a richer mix and level of home care services than those found in other Canadian provinces. The program has been recognized for its comprehensiveness, centralized coordination, referral accessibility from any source and entry into the program at any point, its coordinated assessment for home care and personal care placement, high level of client satisfaction, and committed staff to name only a few of its features. Drs. Robert and Rosalie Kane reviewed the design of the Manitoba program in relation to other jurisdictions and concluded that Manitoba illustrates one of the best long-term care systems in North America. The comments which follow, therefore, are offered in the spirit of constructive criticism. Room for improvement has been recognized for some time and is reflected in the recent Price Waterhouse review of the Manitoba Continuing Care Program (1988). When the recommendations of the Task Force concur with those of the Price Waterhouse review, this is noted.

The Task Force heard from many individuals, read much background documentation, and debated at length the strengths and weaknesses of the Manitoba Home Care program. It concluded there are many problems with this program that must and can be rectified. Specific recommendations are discussed in this section. However, the Task Force believes there is an overall problem of lack of fiscal responsibility and accountability from which many of the other problems flow. The Task Force believes this is a fundamental problem which requires political will to rectify and the urgency of which cannot be understated. It is recommended that:

Recommendation #11: The Minister of Health receive advice on and then implement a structure which will ensure explicit accountability for the Home Care program.

As part of the search for an appropriate structure, an independent board versus incorporation as part of the responsibility of MHSC should be examined.

The Price Waterhouse review identified an urgent need for a redirection of the program in two ways. One referred to a focus of responsibility for program management. That review states that it is not clear who is managing the program because key responsibilities are divided among regional managers, the Office of Continuing Care, administrative services, and other officials. It is also recommended that an infrastructure to ensure service integrity is developed. The review identified a number of problems at both the operational and service levels which relate to inadequate structures and mechanisms to ensure service quality and consistency.

The Task Force heard many similar complaints. The Office of Continuing Care has no line authority over staff. It is responsible for standards and funding but regional operations of the Department of Health deliver the services, together with the services for many other programs. It was argued that staff resources from Home Care were eroded to other programs within the regions. The Office of Continuing Care is accountable for dollars which it does not control. It is our understanding that the Minister of Health is currently investigating a solution to this problem. The Task Force recommends:

Recommendation #12: That OCC control the dollars for which it sets standards and is accountable. The option of having line authority to OCC rather than to the region should be examined within this process.

It is further suggested that while budget targets must be flexible to meet needs, units allocating the dollars must be accountable for their expenditures. Work unit measurement should be introduced in order to argue if more dollars are needed in order to provide more services. For this to work, however, there must be an adequate information system in place. The Task Force therefore recommends:

Recommendation #13: Once a proper information system is in place, budget targets remain flexible in order to meet needs but units must be accountable for budget expenditures. Work unit measurement be introduced for those units arguing the need for more dollars.

The Price Waterhouse review also identified severe staff shortages as characteristic of the Home Care program. Similar charges were heard by the Task Force. There appear to be several reasons for this. Case loads are heavier because the clients represent heavier levels of care than in the past. In addition, the program has expanded by including the younger disabled and other intensive services which OCC was not originally designed to handle. There is general consensus that the program has expanded without a corresponding expansion in resources. The Task Force believes that the understaffing in the Home Care program is a contributing factor to the consistent negative feedback the Task Force heard about this program.

Both from members of the Task Force itself and from individuals presenting to it, the charges laid against this program were surprising and alarming. The accusations included, for example: experiences by the institutional sector of Home Care staff protecting their program territory and not being cooperative with the institutional sector; charges by those in the housing sector that

sufficient services were not available at critical times; charges by users that Home Care took too long to provide an assessment, too long to provide the assistance and when the assistance did arrive it was not performed adequately; misperceptions that doctor referral was necessary in order to receive an assessment for home care services; charges that the Home Care program would not allow other sectors to assist in what was perceived as their task; charges that the system is inflexible. The misperceptions and charges were widespread and did not seem to come from any particular sector.

It is the Task Force's best judgement that one of the major contributing factors to the negative image of the home care program is the severe understaffing of the Home Care program which has been caused by increased demands without increased resources, resulting in high demand, high pressure, and high potential for staff burnout within the program. This has probably led to lessened flexibility and understanding on the part of some staff and particularly staff who interface with other sectors. The Price Waterhouse report claims that high workloads contribute to inappropriate servicing, unauthorized servicing, and unnecessary costs being incurred by the program. The Task Force recommends:

Recommendation #14: The case coordinator/resource coordinator staff complement for the Home Care program be increased according to established case load ratios and work load indices and that these ratios be targeted for each region according to age/sex population adjustments and according to regional diversities in the region.

It is recognized that this calls for additional funding and for an increase in civil service positions. It is believed that both are warranted at this time,

especially when viewed within the broader scope of the whole health care system. As elaborated later, staffing of the Home Care program is considered part of a long-term strategy for providing an appropriate health care system for an aging society, which can impact on the need for long-term institutional care as well as the utilization of acute care services.

There is also concern, however, that the increased demand for home care services is driven substantially by intensive short-term care not originally envisioned for the program (such as early hospital discharges). Unless different sectors of the health care system are viewed together (elaborated later), this can result in a greater resource "richness" for those sectors (such as acute care hospitals) as they discharge patients earlier without closing beds. To be able to examine trends in such demands and to provide home care with a means of dealing with them, it is recommended that:

Recommendation #15: The OCC develop explicit implementation criteria for deciding eligibility of short-term care.

A second contributory factor which the Task Force believes partially explains the negative image which the Home Care program has within various sectors in the community is a lack of adequate communication about this program. On several occasions the Task Force heard misperceptions or unfair complaints directed towards Home Care. For example, it is not true that one needs doctor referral to be assessed for Home Care services. Indeed, its open referral policy has been a hallmark of the program since its inception. Similarly, we heard from more than one individual that home care services are not available on weekends or in evenings for those discharged from hospital. Upon further

investigation it appears that services are available but the hospital discharge planning process must begin early enough in order to allow the Home Care program to ensure the services can be in place. (Case coordinators, however, are not available in the evenings or on weekends and cannot guarantee a quick response to hospital discharge.)

One final example - when individuals do receive particular services, it is not uncommon for them to attribute that service provision to a facility other than Home Care. This is frequently true of residents in the housing units of multi-level care facilities. They may be receiving home care services but they assume and give credit for those services to the facility itself. Home Care must do a better job of informing both potential consumers and other health care workers within the system as to its proper role. To this end, the Task Force supports current efforts to develop a pamphlet describing the program and outlining the client appeal process. The Task Force believes that the education task facing Home Care is broad. The Task Force supports OCC's undertaking to inform the public and other health care workers about the role of the Home Care program and recommends:

Recommendation #16: Information pamphlets on the Home Care program be widely distributed and be available in languages in addition to English.

Now that the brochure has been completed, Task Force members have comments to pass along for the first set of revisions when that time arrives. No data appears on the brochure and no information is provided to assist the individual in finding the correct phone number in the phone book (the only phone number which appears is for appeals). More importantly, members questioned the

understandability of some of the jargon for the average, non-professional lay person who may be a potential user.

To assist Home Care in its interfacing with other sectors of the health care system, the Task Force supports the permanency of the Community Institutional Interface Committee, a subcommittee of the Manitoba Health Services Commission. Much criticism was heard of the fact that Home Care is a sole provider of many services. There was strong consensus that the Home Care program should provide care assessment, care coordination, and funding, and that government be one of the providers of services to avoid a monopoly developing and to be aware of costs. However, the Task Force does not oppose other providers of services. For example, some long-term care facilities have argued that they can provide home care services to their community more cost efficiently than Home Care currently does and they would know their clients better. There may be some practical difficulties in implementation to overcome (such as ensuring a separate body adjudicate applications to avoid conflict of interest). As a policy, the Task Force supports such an option. It might also be noted that some contracting currently occurs (such as to VON). The Task Force recommends that:

Recommendation #17: The Department of Health pursue the option of contracting out, at least on a pilot basis, the provision of services to facilities and other interested agencies.

The Price Waterhouse review recommended the end of the dual assessments for home care services in Winnipeg. The Home Care Division has subsequently argued against this recommendation. Individuals appearing before the Task Force were mixed in terms of whether dual assessments should be maintained. It was

pointed out that those involved in this recommendation from Price Waterhouse were two nurses from Alberta where dual assessments are not part of the process. However, everyone was unanimous that multidisciplinary assessments must be performed. The question, therefore, centres around whether two persons are necessary to accomplish this goal. If adequate training is provided (which apparently is not at the present time because of high work loads), a multidisciplinary assessment tool could be implemented by one person from any of several backgrounds, whether it be nursing, social worker, occupational therapy, etc. Physiotherapists, pharmacists, psychiatric nurses, etc. trained in using the assessment could still be brought in as necessary. The Task Force recommends that:

Recommendation #18: The Office of Continuing Care seriously examine the provision of adequate training for one person to conduct multidisciplinary assessments as a cost effective replacement of the current dual assessment system. This option could include a broader scope of practitioners to conduct assessments than are currently hired and Home Care could ensure that necessary expertise would be available for further consult where necessary.

The Price Waterhouse review also recommended substantial changes regarding the role of the Victorian Order of Nurses within the Home Care program (Page XXXI, Recommendations 1 through 4). These recommendations are strongly supported by the Task Force. At the present time, a V.O.N. does the assessment, coordination, and provision of services. The Price Waterhouse review recommended a separation of these tasks with Home Care personnel doing the assessment and coordination. Furthermore, Home Care has a policy to use the minimum skill level necessary, whereas V.O.N. hires only those with Bachelor of Nursing degrees. Both the separation of function and the hiring of assessors

and coordinators who work for Home Care rather than V.O.N. is supported. This in no way suggests the work of the V.O.N. has not been excellent. Nevertheless, the Task Force recommends that:

Recommendation #19: The Minister of Health take action immediately to remove the inherent conflict of interest in the short-term assessments currently being performed by the V.O.N.

While the Price Waterhouse report notes that a considerable number of new positions will have to be created and funded by Home Care, it is also to be noted that Home Care is currently financing these positions on a contract basis to the V.O.N. In other words, it should not involve a greater allocation of funds but rather a different distribution of those funds. The issue of hospital discharges is also relevant to the acute care sector and will be discussed in a later section.

Considerable discussion also took place concerning the panel for personal home care placement. In particular, some representatives from the institutional sector in Winnipeg argue they should be represented on this panel. The question of self-interest in terms of whether the personal care home wanted the particular type of individual involved or not was discussed. These problems could be prevented and the long-term institutional sector represented by ensuring a representative, for example, from MHO on the panel but with explicit criteria that an individual from the home concerned not sit on that particular panel. It is recommended that:

Recommendation #20: OCC examine the feasibility of having the long-term care sector represented on the panel for placement, ensuring that no individual who may be in conflict of interest would sit on any particular panel.

The province's Price Waterhouse Implementation Committee has been assessing which of the recommendations to implement. We understand they have rejected the concept of user fees and for this the Task Force applauds them. They also intend to maintain universality and consolidate where there is now fragmentation. On all accounts they have the support of the Task Force.

As noted in the Price Waterhouse review, the continuing care program lacks a comprehensive information system which collects and reports client service, management, and financial data on an automated basis. The inefficiency and disadvantages of not having such a system were reported frequently by those who presented to the Task Force. We understand that Coopers Lybrand were subsequently hired to report on a management information system and that an Internal Information Committee has been struck. The Task Force believes the arguments have been well articulated elsewhere and that the necessity for such a system is obvious. It is recommended that:

Recommendation #21: The Minister of Health authorize and Treasury Board fund immediately a proper comprehensive information system that will record client service, management, and financial data for the Office of Continuing Care.

This is consistent with the recommendations of the Price Waterhouse review found on Page XVII, Recommendations 1 through 4.

The community long-term care system is not separate and isolated from the institutional long-term care system. Indeed, general consensus is that the "frontier" has moved over the years. Entry into a personal care home has been delayed over past years by many developments, including the provision of home care services, support services to seniors, SAFER and other housing refit

programs. The physically dependent, with a primary caregiver and other supports within the community, are no longer being panelled to the extent that they were in the past. It is now to a large extent the moderately and extremely cognitively impaired with multiple pathologies who are panelled for PCH.

As already noted, elderly individuals themselves prefer to remain within their own homes in the community for as long as possible. A Home Care program supports this desire. Furthermore, as noted by Shapiro (1987), a policy of providing service on the basis of assessed need has not produced an unlimited demand for service. In 1976, 6% of elders were admitted annually to the Continuing Care program. A decade later this percentage was only 8% despite a substantial drop in nursing home/elderly population ratio and a 29% increase in elders age 75+ (who constitute 85% of admissions to nursing homes). She argues that the acute bed/population ratio and nursing home bed/population ratio and the rise in home care recipients indicates some success of a policy substituting community for institutional care. The ratio of institutional beds is down from 167/1,000 elders age 75 and over to 145. This has happened even though the home care system has not received a higher percentage of the budget than ten years ago. Havens (1985) and Levin (1985) both note that there has been less of an increase in long-term institutional beds with the introduction of the Home Care program than would have been predicted on the basis of the increase in the older population.

It is the strong belief of the Task Force that the Manitoba government must adopt a broad perspective which includes a continuum of care for the health care of elders. That continuum of care includes community long-term care as an equal partner in the provision of care to elders, together with long-term institutional care. The Task Force therefore recommends that:

Recommendation #22: The Department of Health of the Manitoba government continue to endorse community long-term care for meeting the needs of elders as equally important to long-term institutional care.

Long-Term Institutional Care

If we know that elders themselves prefer to remain in the community with support as long as possible and the Home Care program can help them to remain there, the question becomes: What is the most appropriate rate of institutionalization for an aging population, in this case in Manitoba? Unfortunately no one has the answer. If one examines rates of institutionalization it is clear that Canada's rate for elders is high (for those age 65 and over in 1986 it was 6.7% compared with 1985 figures for the United States of 4.6% and 1986 figures for England of 2.7%. Comparable figures for those age 75 and over are 14.4% Canada and 9.6% in the United States. We have been unable to locate figures for those 75+ in England). While there are difficulties in comparing cross-national figures because countries do not use standardized definitions of long-term institutional care, it is widely accepted that Canada's rate is high compared with other industrialized nations. It is not surprising to find, therefore, that Canada's rate of institutionalization is under question. There is reason for questioning the status quo.

As already noted in the section on housing, one of the reasons England's rate is low is believed to be her well-developed system of supportive housing together with an attitude which does not presume that individuals should die within an institution (this issue will be considered in a later report on palliative care). Furthermore, as just noted in the section on home care, that program is seriously understaffed.

Recommendation #23: Given Canada's and Manitoba's relatively high rate of institutionalization and given the current inadequate staffing of the Home Care program, it is recommended that the ratio of long-term institutional beds to population be determined for Manitoba elders after Home Care has adequate management and case and resource coordinators and other problems are corrected, and PCHs are also adequately staffed and sufficient time has been allowed to assess where the pressure points are.

This recommendation assumes changes will be made in the Home Care program relatively soon.

The Task Force recommendation that it is premature to determine whether additional long-term institutional care beds should be built at this time does not include the Minister's recent announcement to build more personal care home beds. The Task Force recognizes both the time expired units at Municipal Hospital and the uneven geographic distribution of personal care home beds. However, it is recommended that:

Recommendation #24: After the completion of the 230 new PCH beds at Municipal Hospital and the 230 new beds in the Northeast quadrant that no additional PCH beds be built until Home Care has been adequately staffed and an appropriate rate of institutionalization for Manitoba's elders is determined.

Once again, this recommendation assumes changes in the Home Care program will be made relatively soon. It is also to be noted that the province has been in the process of converting hostel beds to higher level care beds. There are still 225 hostel care beds which have yet to be converted.

There is clear consensus that both the age and the physical and mental frailty of residents of personal care homes has steadily increased over the past number of years. The average age of admission to long-term care institutions

in Manitoba is now 85 and approximately 60% of new admissions are at the he / care level (personal communication with Kay Thomson, Manitoba Health Services Commission). We do not, however, know the proportion of the institutionalized population who are demented. We do know that staffing levels and qualifications (and funding associated with staffing levels) have not been revised in over a decade and that insufficient funding has been provided to permit staffing to meet approved MHSC guidelines for PCHs. Staff shortages appear in social work, activity, dietetic, and pastoral staff as well as staff development funds. Shortages in these areas will increase demands on existing nursing staff. This is a critical issue which requires attention. The Task Force recommends that:

Recommendation #25: The MHSC appropriately fund and adequately staff PCHs for the heavy care being provided.

As noted at the outset, other major issues concerning long-term institutional care will be dealt with in a subsequent report. Those mentioned here relate specifically to the report of the Task Force on Extended Treatment Beds. The long-term institutional sector is intimately entwined, not only with long-term community care but also with the acute hospital sector. We turn now to a discussion of the acute care sector.

The Acute Care Sector

As noted in the Task Force on Extended Treatment Bed Review final report and the Health Advisory Network Report #1, long-term care beds within acute care hospital facilities are a major concern. At the present time the term "extended treatment beds" is surrounded by confusion. The Task Force on Health Services

for the Elderly strongly endorses the recommendation that the term extended treatment beds be discontinued and the terms rehabilitation beds, personal care home beds, and chronic care beds be adopted. The definitions are as follows:

Rehabilitation Beds: Rehabilitation Beds are of two kinds:

a) those beds required by persons, primarily the elderly, who need rehabilitation or treatment which is of a duration of usually 1 to 6 months because their condition is not amenable to intensive short-term therapy of because the period of recovery is projected to take a long time. The units in which these beds are located often include short-term assessment beds which are used to assess the health status of individuals and/or their rehabilitation potential.

b) those beds in the Rehabilitation Hospital or the Rehabilitation Centre for Children required by persons who need specialized rehabilitation or treatment for complex cases.

Personal Care Home Beds: Personal care home beds are defined as being those beds required by persons who can no longer be cared for at home and whom a multidisciplinary panel judges as requiring admission to facilities licensed to provide personal care. These beds are to be used by persons not requiring chronic care or rehabilitation.

Chronic Care Beds: Chronic care beds are defined as being those beds required by persons who: 1) show little or no potential for rehabilitation; and 2) can no longer be cared for at home or in a personal care home; and 3) require

equipment, specialized professional expertise/treatment and/or continuous physician supervision not usually provided in a personal care home.

The Task Force also supports the recommendations to designate the chronic care and rehabilitation beds within Winnipeg. We strongly endorse the recommendation that appropriate staffing must be concomitant with these designations. It is to be noted, however, that someone in a non-acute care bed can be acutely ill and similarly there can be individuals with chronic care needs in acute care beds in hospitals. The lack of information about these individuals and their needs hampers the planning process in this province. Any information system should be able to identify these individuals. The Task Force agrees with the assessment made by the Health Advisory Network that sound planning for long-term care (for any health care) undertaken in the absence of a reliable and accurate management information system cannot proceed. The Task Force strongly endorses the recommendation of the Health Advisory Network that a reliable, accurate and responsible information system be developed for monitoring the actual use of inpatient facilities for long-term care and for monitoring waiting lists by patient category. It is recommended that:

Recommendation #26: The development of a reliable, accurate and responsible patient information system for long-term care facilities be linked with a similar data system for acute care hospitals.

The Task Force also endorses the recommendations of the Task Force on Extended Treatment Bed Review and of the Health Advisory Network that there be modification to the MHSC personal care home application and assessment form to

make it suitable for chronic care referral and that there be mandatory annual reassessment of occupants of chronic care beds.

The issue of hospital discharge planning emerged several times during our deliberations.There is much concern that hospitals are driving up home care expenditures by their discharge methods. Patients are being discharged earlier but are not as stable and require more intense care than previously. The Price Waterhouse review argues that the program is increasingly used to serve a hospital replacement function. MHSC's Community Institutional Interface Committee has recommended a policy that will require negotiation between acute care facilities and Manitoba Health when changes are instituted in acute care which will increase demand on home care services. We understand the policy is in place but it is too early to know how well it is working.

The issue, however, is not simply one of whether individuals receive treatment in the hospital or in the home. Earlier discharge from hospital can lead not only to increased home care costs but also increased hospital costs as lengths of stay shorten but beds remain full. It is the first few days in hospital when most tests are ordered and hospital costs are greatest. Dr. Gordon Ferguson, Executive Director of New Brunswick's extramural hospital (1989) notes that a number of hospitals in that province have informed him the extramural program has made a positive difference in early discharge from hospitals. However, as their throughput of patients increases, so too does their operating costs.

One option discussed by the Task Force to ensure improvement in the discharge process, together with cost efficiency, would be to turn the discharge planning process over to the hospitals. Since the current arrangement using V.O.N. discharge planners within the hospital is not satisfactory, one could

turn the function and associated funding over to the hospitals when changing this process. If this were to be the case, additional resources to the hospitals for improved discharge planning should be tied to bed closures. This process would have to be negotiated with the hospitals and clear criteria for discharge planning needs would have to be determined. Short-term hospital discharges would have to be linked with home care for those requiring long-term care. The Task Force recommends that:

Recommendation #27: The feasibility of contracting with the hospitals for the discharge planning process be examined in detail.

The issue of cost is an important one and is perhaps nowhere as evident as in the hospital sector which accounts for over half of insured health care dollars. While the hospital sector consumes the greatest proportion of the insured health care dollar, it has been estimated that physicians control as much as 80% of that dollar (Evans, 1984; 1988). On a nation-wide basis, Canadians annually use 200 hospital bed days for each 1,000 population. The rate in the United States is 100 bed days per 1,000 population. As Shapiro has noted (1989), in four years during the 1980s the hospital budget in Manitoba grew by 70%. This was not a period of high inflation and there were not huge increases in labour costs. The population did not grow and the number of hospital beds did not increase.

It is recognized that physicians contain specialized knowledge in order to make their assessments, but it is also recognized that there are many physicians who work only in their clinical practice and will be guided by their experience within that clinical practice rather than by world-wide

epidemiological evidence. Medical interventions and the utilization of hospitals is an issue which extends beyond the health care of elders but includes care during old age. The issue is an important one which has emerged in virtually all of the meetings of the Task Force. These discussions have made reference to the need for physicians to dialogue more with the patient, the lack of awareness by patients of the costs of various interventions, the desirability of a general non-interventionist philosophy unless otherwise indicated, and the desirability of a team approach to health care. The Task Force recommends:

Recommendation #28: The Task Force on Alternative Health Care Strategies examine ways to monitor medical intervention, to increase consumer participation, and to increase all participants' awareness of both the costs and medical outcomes of interventions.

As part of their deliberations, the Task Force on Alternative Health Care is encouraged to examine the establishment of an expert medical panel by the Manitoba Department of Health and the Manitoba College of Physicians and Surgeons which will have the power and authority to examine the intervention trends of physicians as a whole and of individual physicians within the province to see if they are deviating from current knowledge in particular areas. Because of the type of expertise required on this panel, it would include medical researchers, epidemiologists, health economists, and health expertise which is broader than clinical practice per se. The consumers viewpoint should also be represented.

The urgency of these recommendations is highlighted by British Columbia findings (Barer et al., 1988; Evans et al., 1988) demonstrating that the rise in health care costs for elderly individuals is correlated not with changing

morbidity patterns of Canadian elders nor with the increasing proportion of elders in society, but rather with an increased medical servicing of elders by physicians in terms of medical, acute/rehabilitation, hospital care, and long-term care. This increased servicing is rising faster than the increase in the proportion of elders.

As Gill and Ingman (1986) have pointed out, with the explosion in biomedical knowledge it is hardly surprising to see such an increase in service provision. However, this can continue indefinitely, especially given the growing opportunities for intervention during old age. Yet no group in society has yet come to terms with when it is appropriate to intervene during old age.

Changes in medical intervention, though, will not necessarily result in cost savings within the system. Because the payment system is driven by a fee for service formula, services which are less costly would have to be rewarded before one would anticipate cost savings. Another alternative would be the encouragement of salaries for physicians. To date, the Canadian strategy for controlling costs has been to limit overall supply, to stop building hospitals, hospital additions, decreasing the acquisition of new technology, etc. In recent years there has also been some effort to restrict enrollment in medical schools, thereby limiting the future supply of physicians. While hospital space has been relatively stable since 1971 (Evans, 1984), the number of physicians has grown more rapidly. The result has been physicians' access to hospital space has been reduced, limiting his or her billing capacity and increasing pressure on hospitals. Hospitals in Canada are not under any institutionalized pressure to provide the least costly care. Once again, this issue encompasses but is broader than the care of elders. The issue of reimbursement for geriatric care will be dealt with in a later report.

Another problem is the overall coordination within the system. As new procedures such as outpatient surgery are introduced, the aspect of the health care system which it is presumed to effect savings in (in this instance inpatient stays) must show corresponding decreases. In certain instances there may be a transition period before the decrease is effected but without such corresponding decreases costs are going to continue to escalate.

An example of adding to the system but monitoring and decreasing in another sector can be provided. The social workers argued strongly to the Task Force that there is a gap in social work services, particularly after discharge from hospital. Compared to social work services within facilities they are particularly lacking in the community. If more social workers were added, and one of the arguments was that this will reduce readmission to the acute care hospital, then the funding of community social workers should be monitored to assess whether it is leading to fewer hospital admissions. The Task Force recommends that:

Recommendation #29: The Task Force on Alternative Health Care Strategies examine means to ensure that when new interventions or procedures for new interventions are introduced into the health care system, that as a matter of policy, existing aspects of the system will be examined to see where decreases can occur.

Another problem inherent within the system is that typical point of entry tends to be the physician and the acute care hospital. This is expensive. One result is that psychosocial problems show up in emergency wards of hospital because individuals do not know where else to go. Another result is that individuals see physicians because most insurance schemes do not reimburse other

professionals such as physiotherapists unless referred by a physician. This increases the cost of the most expensive health professional within the system, that is the physician, because an individual is obligated or frequently feels obligated to visit that individual first. There are instances in the province where other models are operative and successful. For example, in Hamiota the Task Force was informed that the community does not see the doctor as the gatekeeper. They are comfortable with and do telephone the social worker or the mental health worker directly. Apparently it took community education to reach that point. It is recognized that in an urban centre such as Winnipeg there are problems with fragmentation when the individual goes from one service worker to the next. This is a practical problem and solutions can be found, for example, having individuals keep records of their visits which they would take to any health care visit. Relatedly, Roy Brown, Executive Director of Deer Lodge Centre, notes that acute care is not always the best response for doctors to make for frail seniors. When seniors have difficulty perhaps they should be referred from an EPH not to an acute care hospital but to a comprehensive geriatric facility such as Deer Lodge or Municipals for assessment. (This is not intended to infringe on an individual's choice of a physician.) It is recommended that:

Recommendation #30: The Minister of Health establish a working group to explore ways to ensure elders can access different types of care without necessarily going through a physician.

It is to be noted that this will not necessarily decrease costs. If no changes are made to the system and physicians plus social workers plus physiotherapists, etc. are all provided at no-cost-to-the-consumer, costs will increase. Access

to other health care workers can be cost effective only if it implies less utilization of a current aspect of the system.

Many of the recommendations which appear here are the result of changes that have been and are taking place within Canadian society. Canada, not unlike other industrialized societies, has yet to come to terms with old age as a natural process, distinct from medical intervention. We do not know when it is appropriate for medicine to intervene in the inevitable decline of biomedical function which is part of the usual experience in the later stages of life. Some attention has been directed to the issue of prolonging life in the face of death, but most of this discussion is centred around euthanasia and life saving measures. Collective societal decision-making concerning medical intervention to the very end, taking into account the issues of distributive justice and the best allocation of scarce resources, is only just beginning.

Ultimately the consumer is responsible for the cost of health care and, through elected officials, for the cost of insured services. Yet the public by and large requires greater information concerning both individual responsibility for health and the allocation of health care dollars. The Task Force recommends that:

Recommendation #31: The Task Force on Alternative Health Care Strategies examine ways to educate the public on individual responsibility for health and the allocation of health care dollars.

Other issues in acute care will be dealt with in a later report.

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